AUSTIN BLUFFS ANIMAL CLINIC

4323 Austin Bluffs Parkway
Colorado Springs, CO 80918
(719) 598-7879

Patient:_____ Date:_____ Hm. Phone:_____

Owner:_____ Doctor:_____ Wk. Phone:_____

Drop Off Release Form

Please read and check appropriate:

I have brought my pet to Austin Bluffs Animal Clinic because of the following signs or symptoms:

____Lethargic/Sluggish	____Coughing	____Skin Problem
____Not eating	____Sneezing	____Routine Examination
____Diarrhea	____Hurt Limb	____Routine Vaccination
____Eye Problem	____Other (describe)_____	

While my pet is at Austin Bluffs Animal Clinic, I would like these additional services or items provided:

____Nail Trim	____Routine Vaccination
____Anal Sac Expression	____Heartworm Test or Preventative
____Pet Food	____Pet Supplies
____Other (describe)_____	

Consent

I hereby authorize Austin Bluffs Animal Clinic to perform an examination, any treatment, diagnostic tests, or procedures as deemed necessary for my pet.

I understand that Austin Bluffs Animal Clinic will attempt to contact me before treatment, diagnostic tests, or procedures are performed. In the case that I am unable to be contacted by phone, Austin Bluffs Animal Clinic, its doctors, and staff will use their best judgment and pursue any treatment, diagnostic tests, or procedures that are needed for the welfare of my pet and WILL NOT be liable for any complications or unforeseen circumstances.

I will return at _____a.m./p.m. to pick my pet up, at which time all fees for services rendered will be due.

_____ _____
Signature Date